Progress Through Partnership

Medicaid
Medicare
Management Institute

HEALTH CARE FINANCING ADMINISTRATION JANUARY 1982 ISSUE #2

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MEDICAID MEDICARE EXCHANGE

MEDICAID DIRECTORS MEET IN NEW ORLEANS

HCFA held its 4th State Medicaid Directors' Mid-Year Conference on December 3-4, 1981, in New Orleans. This conference helped States and others to share information and experiences regarding the Title XIX program and its administrative practices, and innovative concepts being applied in the States.

The participants included 108 persons from 43 States, 59 from the Federal sector, and 158 from non-governmental organizations that are involved with Medicaid and/or the delivery of health care services.

Participants exchanged views on State flexibility in administering their Medicaid programs, and the affects of Medicaid budget cuts. Other panel discussion topics covered: implementation of the Omnibus Budget Reconciliation Act of 1981; competitive bidding for the provision of medical services; beneficiary lock-in/provider lock-out programs; freedom of choice requirements; prepaid plans; hospital and nursing home reimbursement; utilization review and changes in the PSRO program; assessing long term care reimbursement; home and community based long term care alternatives; eligibility; fraud and abuse; third party liability; and physician reimbursement. For more information about this conference, call Edward Palder, 301-594-8940, FTS 934-8940. ●

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HCFA RELEASES INDICATORS TO ASSESS DRUG REVIEWS IN LONG TERM CARE FACILITIES

The Health Standards and Quality Bureau (HSQB) has developed guidelines to help surveyors determine compliance with drug regimen review requirements in long term care facilities.

Medicaid and Medicare regulations have required pharmacist or nurse conducted drug regimen reviews in skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and intermediate care facilities for the mentally retarded (ICFs/MR) since 1974.

In these drug regimen reviews, a number of documents (e.g., drug administration records, nursing notes, physician orders, laboratory reports, etc.) are examined. Information collected is analyzed to determine if there are any potential problems with the patient's drug therapy, and whether drug therapy is achieving the stated objectives established by the physician for that patient. If there are potential problems, and/or if stated objectives are apparently not being achieved, then the attending physician must be notified for whatever action he or she determines is necessary.

Eleven studies conducted by pharmacists have demonstrated the cost reduction potential of drug regimen reviews. The potential comes principally from reductions in drug utilization. For SNF patients this reduction could mean a net annual savings of approximately $23 million for the Medicaid and Medicare programs. For ICFs a net annual savings of approximately $30 million could be realized from these reviews. No estimates have been calculated for ICFs/MR. These potential cost savings are exclusive of any that result from prevention of hospitalizations resulting from poor drug therapy management. They also do not reflect the potential for quality improvement.

The indicators consist of six guidelines to assist State agency long term care facility surveyors in determining whether a quality drug regimen review has been performed. The following is a summary of the six indicators.

1. The number of drug regimen reviews performed must be at or near the average census of the facility in any one month, since the regulations require each patient to be reviewed monthly.

2. Drug regimen reviews should be performed in the facility.

3. The average prescription utilization per patient should not be significantly over the 6.1 national average prescription utilization for SNF patients.

4. Reviewer identified drug administration errors should be brought to the attention of the director of nursing and/or the attending physician.

5. Drug therapy problems, such as the need for drug discontinuance, should be brought to the attention of the attending physician.

6. The number of drug therapy problems identified by the pharmacist or nurse should be at least five per 100 patient months of care rendered.

If the State agency surveyor finds that a pharmacist or nurse reviewer has not identified a potential problem described by the indicators, and notified someone with authority to correct the potential problem, then an indication of poor performance of drug regimen review exists.

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HCFA Establishes Cost/Burden Reduction Task Force

HCFA fully intends to curtail rising Medicare costs to stay within fiscal year 1982's funding limitations. To accomplish this Medicare reform initiative, HCFA established the Cost/Burden Reduction Task Force (C/BRTF) that will attempt to reduce the burden and costs to contractors of implementing instructions in the Intermediary/Carrier Manuals, Intermediary Letters, etc. C/BRTF is chaired by John Jansak, Acting Director of BPO's Office of Program Administration.

C/BRTF will systematically review operating instructions in conjunction with the formal performance standards to identify areas in which instructions can be modified or eliminated to reduce the contractors' administrative costs as well as unnecessary burden.

As their first step, the task force compiled more than 100 proposals from the fiscal year 1982 budget process for eliminating or modifying existing instructions or required procedures.

C/BRTF's next step was to establish central and regional office workgroups to specifically address the issue. To assure contractor representation in the undertaking, the contractor community, through its advisory groups (FIG and CRG), was asked to nominate a special technical advisory group (TAG). The special TAG held its first meeting in October in Chicago at the Blue Cross Association's (BCA) headquarters. Representatives attended from both Part A and Part B contractors, including Blue Cross/Blue Shield plans, commercials, and BCA.

The RO/CO workgroups and special TAG has prioritized the 100 proposals from the inventory for indepth review to determine the feasibility of thei implementation and to identify additional proposals for immediate consideration.

C/BRTF has also recommended the implementation of several additional cost savings initiatives for fiscal year 1982. It is also pursuing the feasibility of implementing two of the top priorities identified by the special TAG in order to relieve the budget crunch.

As HCFA moves into the next stage, development of a structured approach to examine operating instructions, the C/BRTF will be relying upon the experience and specialized knowledge of the contractor community to find ways to improve the efficiency of the Medicare operation. Contact: Margaret Ingram, 301-594-9063, FTS 934-9063.

HCFA FOCUSES ON DEMONSTRATION PROJECTS THAT TEST BROAD HEALTH CARE SYSTEM REFORMS

HCFA is now turning its attention to demonstration projects that test broad reforms in the health care system. HCFA has awarded grants to California to aid Santa Barbara and Monterey counties in the development of primary care networks to serve all categories of the Medicaid population. The State will make prospective payments equal to 95 percent of projected costs to the counties who, in turn, will assume risk for Medicaid services. The primary care physicians will act as case managers, providing primary care and authorizing referrals when necessary. Physicians will share in any savings achieved by the system. Enrolled beneficiaries will have free choice among participating providers and will have a 6 month guaranteed eligibility for Medicaid services. In addition, the counties will develop contracts with hospitals and other secondary providers utilizing periodic prospective block payments.

HCFA will issue a special grant solicitation to States for demonstration projects which will enhance competition among insurers and providers of alternative health plans. A primary objective is to have private health insurers participate in these models by offering the Medicaid benefit package on a risk basis. The solicitation is scheduled to appear in the Federal Register in February 1982; States will be given 60 days to respond. The concepts to be demonstrated include:

- Vouchers - States offer vouchers to Medicaid recipients for the purchase of health insurance.
- Contracting with Private Insuring Organizations - Beneficiaries could obtain coverage from private insurance plans, as well as currently approved health care organizations, e.g., HMOs.
- Enrollment Incentives - States will be encouraged to test new marketing incentives such as guaranteed eligibility, cash rebates, and additional benefits covered through cost savings.
- Role of Broker - States will determine whether marketing is most effectively implemented through a broker, by the State, or by individual providers.
- Freedom of Choice - States would be permitted to competitively determine the most cost effective provider plan in an area, and then assign Medicaid eligibles to that plan.

For more information call Ron Deacon, 301-594-1941, FTS 934-1941. ■

THIRTY-SEVEN STATES RECEIVE INCREASED FFP FOR MMIS

Currently there are 37 States receiving 75 percent Federal Financial Participation (FFP) for operation of an approved mechanized claims processing and information retrieval system. States are eligible to receive FFP at an increased rate (75 percent rather than the 50 percent customarily given for administrative costs) if they have a Medicaid Management Information System (MMIS) which has been reviewed and approved by the Federal government. Increased FFP is also available to States for the development of an MMIS; developmental costs, once approved by the Federal government, are matched at the rate of 90 percent FFP.

The District of Columbia, Illinois, and South Dakota are anticipating operation and approval for 75 percent FFP by September 1982. New York State is progressing towards receiving total 75 percent FFP approval on its six remaining regions in development.

Five States are in the planning, designing, and development stages for an MMIS (Connecticut, Kentucky, Massachusetts, Nevada, and Oregon.) Nine States/ Territories do not have an operating MMIS, and two do not have a Medicaid program. For further information contact Bea Smith, BPO's Office of Methods and Systems, 301-594-8441, FTS 934-8441. ●

STATES INVITED TO SUBMIT PROPOSALS FOR PILOT TESTING OF NEW SUBSYSTEMS FOR MMIS

HCFA recently issued Medicaid Information Memorandum IM 81-14, dated December 1981 inviting States to submit advance planning documents (APDs) for pilot testing, validating, implementing and evaluating the design, development, and operation of new and enhanced subsystems for MMIS. HCFA is focusing on the Surveillance and Utilization Review (SUR), Third Party Liability (TPL), and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) subsystems. The new and enhanced subsystems' General System Designs (GSDs) reflect recent legislative and regulatory changes and should be considered a management tool for cost savings through the use of improved technology. The number of States participating in the pilot will be limited. For additional information contact Nelson B. Berry, 301-594-4884, FTS 934-4884. ●

LITIGATION IN BRIEF

Following are recent reimbursement, coverage, and/or eligibility court decisions in civil litigation involving the Medicaid and Medicare programs. Call John R. Bader of HCFA's Civil Litigation Branch on 301-594-9708, FTS 934-9708, for further information about these cases and about judicial developments concerning Medicaid and Medicare in general.

POSITION ON LABOR ROOM DAYS' ISSUE UPHELD

In the first court test involving the merits of the labor room days' issue, the District Court for the District of Columbia has upheld the Medicare program's inclusion of the labor/delivery room days in computing routine inpatient service reimbursement for St. Mary of Nazareth Hospital Center.

In reaching this conclusion, the court considered the rapidly increasing cost of health care. It recognized that there are strong arguments for both inclusion and exclusion of the labor room days in the computation. Nevertheless, the regulations could reasonably be construed as requiring inclusion of the days in computing the per diem. Since there was a rational basis for Medicare's method of reimbursement, the issue was upheld.

NO RETURN ON EQUITY CAPITAL FOR NONPROFIT HOSPITALS

A Federal district court in Georgia has concluded that nonprofit hospitals are not entitled to Medicare reimbursement for a return on equity capital.

In Hospital Authority of Floyd County, Georgia, the first court test involving this controversial issue, the court reviewed the legislative history leading to the 1966 statute enactment which calls for the return on equity to be reimbursable only for proprietary extended care facilities. The court concluded that Congress meant to differentiate between proprietary (profit) and nonprofit institutions.

The court pointed out that the regulation that was discontinued in 1969 provided nonprofit facilities with a two percent allowance intended to provide reimbursement for a return on equity. Congress has amended the Medicare Act substantially since that time but has left the 1966 provision intact. The court mentioned that failure to amend the law to provide a return on equity for both proprietary and nonprofit facilities vindicates the Medicare regulation limiting the return to proprietary facilities.

The court also rejected the argument that the regulations are unconstitutional. A rational basis exists for treating profit and nonprofit institutions differently, the court concluded. Nonprofit institutions have benefits the proprietary institutions do not have, such as tax-exempt status, Hill-Burton grants, charitable donations, and other advantages from State and Federal governments.

HILL-BURTON ACT CONTROVERSY

In Metropolitan Medical Center, the Federal District Court in Minnesota held that the Medicare program must reimburse the provider for the cost of "free care," which the provider became obligated to render as a condition for obtaining a Hill-Burton subsidy. The court found that these costs indirectly benefit Medicare patients because they help the provider qualify for interest subsidies on construction loans. These loans can be used to build facilities serving both Medicare and non-Medicare patients.

Of the six courts that have considered this issue, five supported the providers, including a circuit court (Presbyterian Hospital of Dallas, 5th U.S.C.A.). Only the district court for the Eastern District of Michigan (Harper-Grace Hospitals) favored the Secretary.

HCFA will seek appeal of this case, looking ultimately to a Supreme Court resolution of the issue.

PSROs NOT SUBJECT TO FOIA DISCLOSURE

In a two to one decision, the U.S. Court of Appeals for the District of Columbia has held that Professional Standards Review Organizations (PSROs) are not "agencies" of the Federal government, as defined in the Freedom of Information Act (FOIA), and, therefore, are exempt from FOIA disclosure rules.

In reaching this decision, the court in Public Citizens Health Research Group emphasized such factors as the independence of PSROs (they are independent corporations, composed of physicians who are not government employees, and are not subject to day-to-day control by the government) and the clear congressional intent that physicians, rather than the government, be responsible for Medicaid and Medicare health care review.

Despite the numerous regulations detailing PSRO's functions and their decision-making authority relative to admissions, medical necessity, and length-of-stay determinations, the court said that the PSRO in this case was "an organization of private physicians," more similar to an independent contractor than to a governmental agency. The disclosure of PSRO records and documents is not required under the FOIA, the court concluded. ■

CAPITALIZING STATE RESOURCES

M/MMI's Corrective Action Projects Division (CAPD) provides technical assistance and professional consultative services to State Medicaid agencies. CAPD focuses its efforts on resolving problems which significantly contribute to Medicaid quality control errors. Through CAPD, States are afforded the expertise needed to implement operational improvements in their programs in third party liability (TPL), data exchange, and error prone profiling/eligibility management. For additional information about CAPD call Arthur Pergam, CAPD Director, 301-594-8942, FTS 934-8942.

CAPD MAKES RECOMMENDATIONS TO NORTH CAROLINA AFTER REVIEWING THE STATE'S ERROR PRONE PROFILE

CAPD has generated and analyzed an error prone profile from a randomly selected sub-sample of North Carolina's MQC data for the review period October 1979 to March 1980. The profile identified both the primary and secondary characteristics of those cases most likely to be in error. The profile also indicated that 15.39 percent of the MQC sample possessed some combination of the identified characteristics. Subsequent review of those cases revealed that 88 percent of all State MQC errors could be located within the parameters of the profile.

The primary characteristic, the absence of unearned income, was the predominant factor in the profiled error cases. Secondary characteristics, associated case characteristics, which further increased the probability of error included receipt of RSDI (railroad and survivor disability insurance) benefits, receipt of cash payments in AFDC families, presence of liquid assets, and recent approval of Medicaid applications.

The profile also revealed that 77 percent of all errors generated in the State were due to the agency's application of incorrect policy or failure to verify information as required, or both. Client sources of error accounted for the remaining 23 percent errors and were related to changes in circumstances that were not reported by the recipient or incorrect information supplied by the recipient, or both.

In response to the State's error prone profile findings and review of North Carolina's case management procedures, CAPD staff recommended that the State conduct more intensive reviews of identified error prone case-types. CAPD recommended to the State that they use intensive interviewing techniques and complete verification procedures during the application and redetermination processes. CAPD also suggested that the State develop appropriate training packages designed to assist workers in obtaining maximum resource information from recipients during interviews and that training be conducted on a Statewide basis. Contact: Chris Johnson, 301-594-9522, FTS 934-9522.

MEDIGAP LAW ENCOURAGES STATES TO REDUCE SALE AND MARKETING ABUSES OF MEDIGAP POLICIES

The Medigap law (Section 1882 of Title XVIII of the Social Security Act) signed on June 9, 1980, was a Congressional effort to create an incentive for States to upgrade their regulation of privately issued Medicare supplemental health insurance policies (commonly known as Medigap policies) in order to curb the many abuses in connection with the marketing and sale of these policies. The law created a Supplemental Health Insurance Panel and established a Voluntary Certification Program.

The Panel is chaired by Tera S. Younger, Director of HCFA's Bureau of Program Operations (BPO). The President appointed four State Insurance Commissioners to sit on the Panel. The appointed Commissioners are: W. H. L. Woodyard, III, Arkansas; Joseph C. Mike, Connecticut; Roger C. Day, Utah; and, Susan M. Mitchell, Wisconsin. The Panel determines whether a State's Medicare supplement program meets or exceeds certain statutory standards adopted by the National Association of Insurance Commissioners (NAIC) in their 1979 Model Regulation and whether or not certain loss ratio requirements mandated by the law are met. The loss ratio is the ratio between the amount of insurance benefits paid out to insurance premiums paid in.

The Panel recently submitted a report to the Secretary of Health and Human Services to be forwarded to Congress. This report identified those States not expected to meet or exceed the minimum standards established in the law. It showed that 43 States and 2 jurisdictions are expected to meet or exceed the requirements by July 1, 1982. Seven States and three territories are not expected to meet the minimum requirements by that date. The Panel will continue to review those States which do not have approved regulatory programs to determine if they subsequently do adopt the minimum requirements, as well as to monitor those States which have approved regulatory programs to assure they continue to meet the standards.

The Voluntary Certification Program will go into effect on July 1, 1982, in those seven States and three territories not having a Panel approved program. This program will allow insurers to voluntarily submit Medigap policies to the HHS Secretary for review. Those meeting the Federal minimum standards will be permitted to bear a Federal emblem, certifying their compliance with the minimum requirements established by law. These policies will have to be reviewed and analyzed yearly to receive continued certification. As mandated in the law, a report is due to Congress by July 1, 1982, and periodically thereafter as appropriate. This report will discuss the effectiveness of the Voluntary Certification Program.

In less than two years, the Medigap law has encouraged most States to take the first step in solving some of the abuses connected with the sale and marketing of Medigap policies, a concern of many of our senior citizens today.

BPO's Medigap Operations Staff (MOS) was formed in 1980 to be the focal point for all Medigap related issues. MOS is responsible for supplying staff support to the Panel and for implementing the Voluntary Certification Program. For further information, contact Robert A. Silva, MOS Director, 500 East High Rise, 6325 Security Boulevard, Baltimore, MD, 21207, 301-594-9412, FTS 934-9412.

REGULATION

Following are recent HCFA regulations of interest to Medicaid and Medicare program managers. Questions may be directed to the contact persons listed with each regulation.

Medicaid and Medicare Programs: Less Than Effective Drug Products Subject to a Notice of Opportunity for Hearing - General Notice
10/21/81 Federal Register
Contact: Henry Hehir, 301-594-8561, FTS 934-8561, or Herbert Gerstenzang (Food and Drug Administration) 301-443-3650

Privacy Act of 1974; Systems of Records: Annual Publication - Notice
10/27/81 Federal Register
Contact: Russ Robertson, 202-472-7453

Medicaid and Medicare Programs: Less Than Effective Drugs (42 CFR Parts 405 and 441) - Notice of Court Order Affecting Enforcement of Interim Final Rule with Comment Period
10/30/81 Federal Register
Contact: Henry Hehir, 301-594-8561, FTS 934-8561

Medicaid and Medicare Programs: Correction (42 CFR Parts 405, 431, 433, 435, 436, 440, 447, 456, 463, 466, and 478) - Correction of Interim Final Rules
11/04/81 Federal Register
Contact: Nola Petrovich, 301-594-9711, FTS 934-9711

Statement of Organization, Functions, and Delegations of Authority - Notice
11/06/81 Federal Register
Contact: Thomas Brennan, 301-594-8662, FTS 934-8662

(Department Regulation) Semi-Annual Agenda of Regulations - Proposed Rule
11/10/81 Federal Register
Contact: John Casciotti, Deputy Executive Secretary, Office of the Secretary, Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201, 202-245-7462

Medicare Program: Availability of Information and Records to the Public (42 CFR Part 401) - Final Rule
11/12/81 Federal Register
Contact: Stanley Katz, 301-594-9595, FTS 934-9595

Statement of Organization, Functions, and Delegations of Authority - Notice
11/19/81 Federal Register
Contact: Thomas Brennan, 301-594-8662, FTS 934-8662

Health Financing Research and Demonstration Grants; Cancellation of Grants Solicitation - General Notice
12/01/81 Federal Register
Contact: Frances Lariviere, 301-594-7474, FTS 934-7474

REVIEW

Medicaid Program: Public Notice of Changes in Method or Level of Reimbursement (42 CFR Part 447) - Interim Final Rule with Comment Period
12/03/81 Federal Register
Contact: William Hickman, 301-594-9101, FTS 934-9101

Medicare Program: Availability of Information and Records to the Public (42 CFR Part 401) - Correction
12/04/81 Federal Register
Contact: David Higbee, 301-594-9638, FTS 934-9638

Medicaid and Medicare Programs: Omnibus Budget Reconciliation Act of 1981; Information Notice on Medicare and Medicaid Amendments - General Notice
12/14/81 Federal Register
Contact: Sharon Harris, 301-594-9774, FTS 934-9774

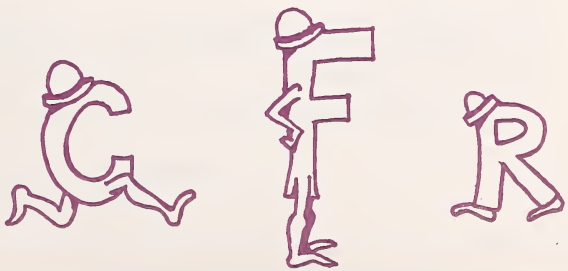
Pharmaceutical Reimbursement Board; Suspension of Maximum Allowable Cost Limits on Specific Drug Products - Suspension Notice for the Maximum Allowable Cost on Dicloxacillin Sodium, Oral Capsule, 250 mg.
12/21/81 Federal Register
Contact: Charles Spalding, 301-594-5403, FTS 934-5403

Privacy Act of 1974; Report of Altered System - Notice of Altered System
12/24/81 Federal Register
Contact: Jean Harris, 301-594-9868, FTS 934-9868

Medicare Program: Solicitation of Comments Related to a Study of Methods for Improving Coverage of Registered Dietitians' Services and for Respiratory Therapy Services Provided by Home Health Agencies - General Notice
12/31/81 Federal Register
Contact: Mildred Corbin, 301-597-1457, FTS 987-1457

Medicare Program: Solicitation of Comments Related to a Study of Methods for Improving Coverage of Foot Care Services - General Notice
12/31/81 Federal Register
Contact: Alice Litwinowicz, 202-245-6306

Medicare Program: Determination of Reasonable Charges (42 CFR Part 405) - Interim Final Rule with a Comment Period
12/31/81 Federal Register
Contact: Paul Riesel, 301-597-1843, FTS 987-1843



CORRECTION TO LAST ISSUE'S BENEFICIARY AWARD ARTICLE

The article, "Individuals and Groups Awarded for Outstanding Service to Beneficiaries," on page 17 of the November 1981 MMX failed to name HCFA personnel who also received Beneficiary Services Certificates of Merit. The following HCFA employees were awarded certificates for either outstanding performance in service to beneficiaries or for a major contribution in the area of beneficiary services.

Central Office

Dominic C. Jollie
Bureau of Program Policy
Baltimore, Maryland

Region IV

Wayne Cole
Lola Parks
Steve Schlachter
Glenn Smith
Janis Wilson
Division of Program Operations
Beneficiary Services Branch
Atlanta, Georgia

Region VI

Betty J. Collins
Division of Program Operations
Dallas, Texas

Region VII

John C. Mowry
Ruth J. Muldoon
Ona C. Owens
Walter J. Siebert
Robert Welch
Division of Program Operations
Kansas City, Missouri

We apologize for this error. ■

Editor

HCFA DESIGNATES MEDICARE INTERMEDIARIES TO SERVE FREESTANDING HHAs

HCFA has selected regional intermediaries to serve freestanding home health agencies (HHAs) as required by the Omnibus Reconciliation Act of 1980 (P.L. 96-499).

This provision was enacted because of concern about fraud and abuse resulting in overpayments to HHAs, and interest in improving contractual arrangements with the private sector for administering the Medicare program. This provision assures that each intermediary has a sufficient number of HHAs to develop expertise in claims adjudication and audit activities while giving priority attention to their HHA workload.

HCFA has consolidated the workload of freestanding HHAs so that almost every State is serviced by a single intermediary. This will improve management and control of coverage and reimbursement determinations for HHAs, ease intermediary onsite review, and enhance delivery of necessary services. The number of intermediaries serving freestanding HHAs has been reduced from 72 to 49.

HCFA believes that the vast majority of reassigned HHAs will be able to establish good working relationships with designated intermediaries. For further information, or a listing of designated intermediaries, call your local HCFA regional office. ■

Health Care Financing R&D Reports

This column lists research, demonstration, and statistical data published by HCFA's Office of Research and Demonstrations (ORD).

Research Reports

Statistical Reports

There were no additional research or statistical reports published since those listed in MMX issue #1 dated November 1981.

Other Reports

Following is a listing of final reports that can be purchased from:

National Technical Information Services
Document Sales
5285 Port Royal Road
Springfield, VA 22151
703-487-4650

- Evaluation of the Colorado Clinical Psychology-Expanded Mental Health Benefits Experiment (Executive Summary) -- PB82 136144
- Evaluation of the Colorado Clinical Psychology-Expanded Mental Health Benefits Experiment Volume I: Description of the Experiment -- PB82 136151
- Evaluation of the Colorado Clinical Psychology-Expanded Mental Health Benefits Experiment Volume II: Process Evaluation -- PB82 136169
- Evaluation of the Colorado Clinical Psychology-Expanded Mental Health Benefits Experiment Volume IV: Beneficiary Survey -- PB82 136185
- Evaluation of the Colorado Clinical Psychology-Expanded Mental Health Benefits Experiment Volume V: Impact of the Experiment on the Use, Cost and Delivery of Medicare Service -- PB82 136193
- Design of An Evaluation of PSRO Long Term Care Review: Final Report -- PB82 131616
- Differential Reimbursement of Hospitals -- PB82 138124

ORDS SPLITS INTO TWO SEPARATE OFFICES

HCFA's Office of Research, Demonstrations, and Statistics has been divided into two separate offices; the Office of Research and Demonstrations (ORD), and the Bureau of Data Management and Strategy (BDMS).

ORD reports directly to the Associate Administrator for Policy, Patrice Hirsch Feinstein. Steven Pelovitz is the Acting Director of ORD. ORD consists of two offices; the Office of Research (headed by Dr. Judith Lave), and the Office of Demonstrations and Evaluations (headed by Barbara Cooper). Mr. Pelovitz can be reached at 301-597-3195, FTS 987-3195.

BDMS is under the Associate Administrator for Management and Support Services, James Donovan, M.D. Dennis Fischer is BDMS' Director, and Dr. James Kaple is the Deputy. BDMS includes three offices; the Office of Financial and Actuarial Analysis (headed by Roland King), the Office of Statistics and Data Management (headed by Carol Walton), and the Office of Information, Planning and Development (headed by William Cresswell). To contact Mr. Fischer call 202-245-6257, or 301-597-2448, FTS 987-2448.

HCFA HAPPENINGS

OFFICE OF CHILD HEALTH IS REORGANIZED

As part of HCFA's recent functional realignment, two major bureaus have received Office of Child Health responsibilities for administering the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

The Bureau of Program Operations' Office of Standards and Performance Evaluation (OSPE) now includes a Child Health Staff unit, which is responsible for the programmatic and operational aspects of Medicaid's preventive child health program. The Bureau of Program Policy's Offices of Coverage Policy and Reimbursement Policy are responsible for addressing EPSDT policy questions. Child health staff can be reached at:

Bureau of Program Operations
Office of Standards and Performance Evaluation
Child Health Staff
ATTN: William Hiscock, Acting Director
Meadows East Building
6300 Security Boulevard
Baltimore, MD 21207
301-594-4212, FTS 934-4212

Bureau of Program Policy
Office of Coverage Policy
ATTN: Stephen Leeds
East High Rise Building
6325 Security Boulevard
Baltimore, MD 21207
301-594-8564, FTS 934-8564

MMMI EVENTS

Carrier Representative Group
(CRG) Meeting
February 3 Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS 934-9455

Fiscal Intermediary Group
(FIG) Meeting
March 10 Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS 934-9455

Carrier Representative Group
(CRG) Meeting
May 5 Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS 934-9455

State Medicaid Group
(SMG) Meeting
February 9 Baltimore, MD

Contact: Edward Palder
301-594-8940
FTS 934-8940

State Medicaid Directors'
Mid-Year Conference
April 26-29 Salt Lake City, UT

Contact: Edward Palder
301-594-8940
FTS 934-8940

READERS ARE ADVISED TO WATCH
THIS SPACE FOR UPDATED
SCHEDULES OF EVENTS

MEDICARE PART A DEDUCTIBLE AND COINSURANCE INCREASE ON JANUARY 1, 1982

Effective January 1, Medicare hospital deductibles under Part A rose from $204 to $260 for the first 60 days of services. Coinsurance for the 61st to the 90th day increased from $51 to $65 a day. Cost for the 60 reserve days went up to $130 a day. Coinsurance for services provided at a skilled nursing facility during the 21st through the 100th day of stay also increased from $25.50 to $32.50 a day.

Beneficiary notices of the increase were enclosed with all social security benefit payments in December. Direct deposit beneficiaries were notified by self-mailer. In addition, a notice was enclosed with the Medicare monthly and quarterly premium billing notices mailed in December and the quarterly notices mailed in January and February. For more information, call Jean Hendricks, 301-594-9604, FTS 934-9604.

Legislative Ledger

On December 16, H.R. 5297 was introduced to the Committee on Ways and Means amending Part D of Title IV of the Social Security Act. This bill would allow families to collect past due child and spousal support from Federal tax refunds which are presently available to AFDC (Aid to Families with Dependent Children) families. Also on that date, H.R. 5304 was announced to both the Committees on Ways and Means, and Energy and Commerce. Under this bill, Medicare would provide Part A coverage for alcohol detoxification facility services.

Three bills were established on December 11. H.R. 5180 would provide Medicare coverage for hospice care, and H.R. 5194 would provide Medicare coverage for influenza vaccine and its administration. Under the third bill, H.R. 5199, States would be permitted to provide Medicaid coverage to certain dependent children and relatives without regard to certain work disincentives imposed by the Omnibus Budget Reconciliation Act of 1981.

H.R. 5093 was introduced to the Committee on Energy and Commerce on November 21, 1981. This bill is designed to require Medicaid to pay for home care coverage for certain disabled children who are otherwise entitled to such coverage only if provided in a costly medical institution.

A bill (S. 1762) amending Part A of Title IV of the Social Security Act with respect to the earned income disregard was brought forward to the Committee on Finance on October 22, 1981. Within the AFDC program, most welfare recipients are able to work and should have an incentive to work. The Social Security Amendments of 1967 established the $30 and one-third earned income disregard. This meant that recipients could keep $30 of each month's earnings, plus one-third of all additional earnings, plus pay for work related expenses and children's day care. The Reconciliation Act eliminated this incentive. S. 1762 tries to restore the earned income disregard but in a different way.

Under S. 1762 for each month that the recipient works, he/she would be able to deduct the first $75 of earned income, up to $160 of child care expenses, and $30 and one-third of the remainder of earned income. The law would remain in effect after the fourth month of employment, except that the recipient could keep, after deductions for child care and work expenses, only $30 and one-fifth of the rest of his/her earnings. This bill is an attempt to reintroduce a work incentive into the AFDC program.

On October 20, 1981, the Committee on Finance was introduced to a bill that would remove the three-day prior hospitalization requirement for Medicare coverage of extended care services. S. 1754 would amend the Social Security Act to stop forcing older Americans to shuttle between nursing homes and hospitals just to meet costly paperwork requirements. This amendment is intended to eliminate the current requirement that a Medicare beneficiary spend three days as a hospital inpatient before eligibility for a skilled nursing facility can be established. Deleting this requirement will reduce unnecessary hospitalization and put an end to the traumatic transferring between hospitals and nursing homes that the current requirement entails.

For further information on these or other HCFA legislative issues, call Richard Chambers, HCFA's Legislative Reference Office, 202-426-3717. ■

Personnel

MEDICARE

Part B Carrier

Name Change - The Occidental Life Insurance Company of California is now known as the Transamerica Occidental Life Insurance Company.

HCFA

Central Office

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Dr. George Schieber - Director, Office of Policy Analysis, Office of Legislation and Policy

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William Hogsten - Director, Office of Methods and Systems, Bureau of Program Operations

Harold Wienberg - Deputy Director, Office of Methods and Systems, Bureau of Program Operations

Don Novitski - Acting Executive Officer, Executive Office, Bureau of Program Operations

ACTION TRANSMITTALS

These Action Transmittals were issued by HCFA in November and December 1981.

AT-81-37 Title XIX, Social Security Act: Medicaid Eligibility and Coverage Criteria (Refer to: 42 CFR Parts 435, 436 and 440; Federal Register on Wednesday, September 30, 1981, 46 FR 47976 effective October 1, 1981)

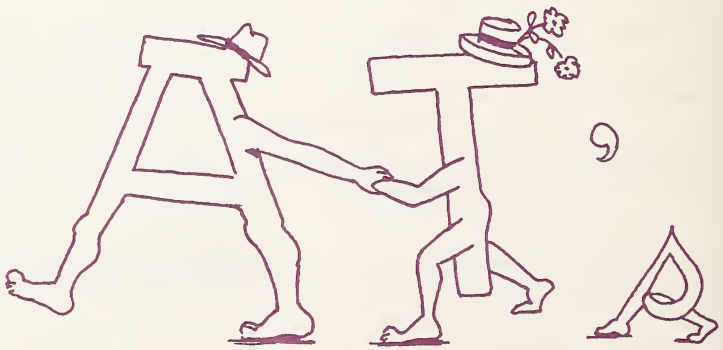
AT-81-38 Title XIX, Social Security Act: Freedom of Choice and Payment for Long Term Care Facility Services and Inpatient Hospital Services (Refer to: Freedom of Choice - 42 CFR 431.50, 431.51, 431.54, 431.55; 440.200, 440.250; Federal Register, Thursday, October 1, 1981, 46 FR 48524 effective October 1, 1981: Long Term Care Facility Services and Inpatient Hospital Services Payment - 42 CFR Part 447, Subpart C, Federal Register, Wednesday, September 30, 1981, 46 FR 47964 effective October 1, 1981)

AT-81-39 Title XIX, Social Security Act: Miscellaneous Provisions (Refer to: 42 CFR 433.139, Federal Register, Thursday, October 1, 1981, 46 FR 48556 effective October 1, 1981)

AT-81-40 Revised Draft Report on Provider Participation in the Medicaid Program

AT-81-41 Title XIX, Social Security Act: Public Notice of Changes in Method or Level of Reimbursement (Refer to: 42 CFR 447.205; Federal Register, Thursday, December 3, 1981, 46 FR 58677, effective December 3, 1981)

NOTE: There were no additional Information Memorandums published since those listed in the last MMX issue (November 1981).



Trainers...Take Note!

The Medicaid/Medicare Management Institute has produced a 35mm slide presentation entitled, "A Health Care Financing Administration Briefing on Medicare and Medicaid." The presentation consists of four parts. The first three parts review the national health picture, Medicaid, and Medicare. The fourth section compares and contrasts Medicaid and Medicare.

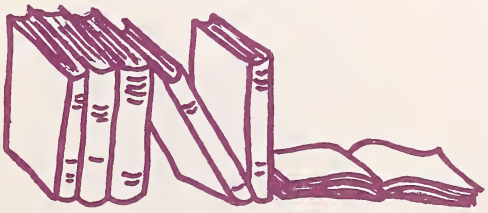
The package includes 46 slides, and an instructor's guide. The 46 slides contain statistical material as well as general information. The slides are an ideal starting point for an indepth group discussion on Medicaid and Medicare. The 102 page instructor's guide includes a brief section for trainers describing how to use the package. It also contains pictures of the slides along with supplementary information.

Those who use the training package might choose to focus on a single section instead of using the whole training package at one time because of the amount of information contained in each section. Finally, the instructor's guide can be used as an individualized learning text.

The training package is designed for basic and refresher training of both HCFA and Social Security Administration employees. It can also be used by the staff of Medicaid State agencies, Medicaid fiscal agents, Medicare contractors, and others interested in the programs.

Copies of the complete training package including slide trays and instructors' guides have been sent to all HCFA regional offices. Each region will set up its own distribution system and lending plan. If you are interested in borrowing this training package, contact your local regional office or Joseph Boston from M/MMI at 301-594-8648, FTS 934-8648.

If you would like to share your training experiences, or would like to discuss topics that are covered in the column, call Susan Eberhard of M/MMI's Consultation and Training Branch at 301-594-8655, FTS 934-8655.



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HCFA Releases Indicators - continued from page 2

Before these indicators were recommended for adoption, they were tested by the Mississippi State Survey Agency. Eleven health facility surveyors applied them to 29 SNFs. These surveyors rated the indicators' usefulness at 7.6 on a 10 point scale. A number of pharmacy, medical, nursing home and consumer groups were also consulted before the indicators were adopted.

HCFA emphasizes that the indicators are not regulations. They are merely surveyor guidelines to be used to determine compliance with the drug regimen review. A long term care facility cannot be required to comply with the indicators. However, considerable variance from the indicators can be justification for a non-compliance finding relative to the drug regimen review requirement.

The indicators are expected to result in better quality drug regimen reviews in long term care facilities. Enhancement of drug regimen reviews is expected to improve the quality of drug therapy and reduce its costs. The indicators will become effective on April 1, 1982.

Those interested in the details of the indicators are urged to obtain a complete copy from Dr. Samuel W. Kidder, 301-594-1814, FTS 934-1814. ■

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